



Commission of Correction

THOMAS A. BEILEIN
Chairman

PHYLLIS HARRISON-ROSS, M.D.
Commissioner
September 30, 2016

THOMAS J. LOUGHREN
Commissioner

Sheriff Timothy B. Howard
Erie County Sheriff's Office
10 Delaware Avenue
Buffalo, New York 14202

RE: David Liddick
DOD: 9/20/14
FAC: Erie County Holding Center
MRB#: 14-M-125

Dear Sheriff Howard:

The Commission of Correction and its Medical Review Board (MRB) are in receipt of the August 10, 2016 letter from Erie County Attorney Michael Siragusa, in which he sets forth the county's response to the preliminary report of the MRB in the Matter of the Death of David Liddick, who at the time was an inmate at the Erie County Holding Center.

The Board reviewed the response in detail at its regular meeting of September 1, 2016 and at that time recommended that the Commission endorse amendments to Findings 3, 5, 7, and 9 to the Commission's Final Report. Beyond this, the MRB found no further changes to the findings were warranted, while several elements of the response were deemed to warrant further comment.

The Board concludes that the response to the substantive findings and recommendations, as set forth in their original report, were unacceptable and dismissive of the cited critical lapses in medical care provided to David Liddick. The MRB rejects the notion that compliance with approved protocols from US Department of Justice's correctional healthcare monitoring activity satisfies any assurance that Erie County Holding Center is consistently providing proper medical care to prisoners in their custody. The delivery of proper medical services requires competent medical providers capable of exercising sound medical judgment, making correct diagnosis, who are and utilizing effective treatments within the accepted standards of care.

The county's response to Finding 13 states that had a cardiac event been evident the entire protocol would have been followed and the patient transferred to an outside hospital. This response goes on to assert that given Liddick's non-compliance with his medication regiment for diabetes and his history of hypertension, the *"likelihood he was experiencing a cardiac event would be highly considered"*. Seemingly, if the index of suspicion was that Liddick was experiencing a cardiac event, this raises the question of why medical staff failed to follow the full cardiac protocol and delayed consulting with a physician until fifty (50) minutes after the clinical encounter and at a point the patient was no longer present.

These documented actions by the facility's medical staff, in the context that Liddick may have been a potential cardiac patient, contradicts the position put forward on behalf of the county

that proper medical protocols were followed in this matter. The response further dismisses the MRB's finding of compounded failures by the facility's medical staff, extending over multiple encounters, to adequately address Liddick's continued complaints of abdominal pain. Over the course of this event, facility medical staff further failed to recognize the need and opportunity to implement reasonable corrective actions in order to minimize any reoccurrence of past lapses in their professional performance.

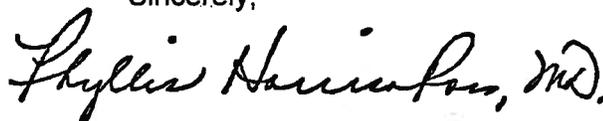
Therefore, it is the position of the MRB that the repeated failure of medical staff to properly respond to Mr. Liddick's continued complaints, caused by a critical condition that was detectable, and which if addressed in a timely manner, would have necessitated hospitalization and surgical intervention, is evidence of grossly incompetent medical care on the part of facility medical personnel. As it is part of their mission to identify and address issues that will prevent further in-custody deaths from occurring, the MRB requests that more thorough consideration be given to their findings in this case.

You should be aware that some of the medical and/or mental health information contained herein may be prohibited by law from secondary dissemination. Therefore, you should check with your county attorney or other legal advisor prior to releasing any information contained in this report or its attachments, if any.

Accordingly, the enclosed Final Report was adopted by the Board at its regular meeting of September 1, 2016 and approved by the Commission at its regular meeting of September 27, 2016. Please be advised that this report will become available to the public pursuant to New York's Freedom of Information Law on October 4, 2016.

If you have any questions, please do not hesitate to contact our office at (518) 485-2464.

Sincerely,



Phyllis Harrison-Ross, M.D.
Commissioner & Chairperson
Medical Review Board

Attachment

Cc: Daniel Malloy, MD, Jail Physician
Erie County Holding Center
Gail Burstein, MD, Commissioner
Erie County Department of Health
John J. Mills, Chair
Erie County Legislature
Michael A. Siragusa
Erie County Attorney